Consent for Initial Multidisciplinary Evaluation

Child's Name: _____ Date of Birth: _____

On _____(date), _____(child) was referred for an multidisciplinary evaluation to determine eligibility for early intervention services. We are requesting your permission to evaluate your child. Also, as a parent of a child who may eligible for early intervention services, the *Rights of Infants and Toddlers with Special Needs* brochure is being provided for your information.

The procedures that have been recommended for your child's evaluation are checked below:

___ 1.Audiological Evaluation
___ 2.Developmental Evaluation
includes:
Cognitive
Motor
Communication
Social-Emotional
Adaptive

___ 3.Medical evaluation
___ 4.Occupational Therapy Evaluation
___ 5.Physical Therapy Evaluation
___ 6.Psychological Evaluation
___ 7.Speech/Language Evaluation
___ 8.Vision/hearing Screening
___ 9.Vision Evaluation

Your signature <u>does not</u> give permission for the initiation of early intervention services. When the multidisciplinary evaluation has been completed, you will be invited to a meeting. At this meeting, we will discuss the findings of the evaluation and determine if your child is eligible to receive early intervention services. If your child is eligible for early intervention services, then an appropriate plan will be developed.

You are *encouraged to participate in the planning* of your child's multidisciplinary evaluation. Your service coordinator will discuss with you various methods of participation prior to the evaluation.

I HAVE REVIEWED THE ENCLOSED BROCHURE, "*THE RIGHTS OF INFANTS AND TODDLERS WITH SPECIAL NEEDS*" and have been given the opportunity to ask questions about the brochure. ___Yes ___No

Please check all of the following that apply:

___ I give written consent for the above evaluation procedures.
___ I do not give written consent for all of the above evaluation procedures.
___ I give written consent for the above evaluation procedures except for the following:
_____
_____
___ I have been informed about the evaluation process and how the information from the evaluation will be used.
___ I have been invited to participate in the evaluation process as I wish.

Date: _____ Signature of Parent or Guardian_____
Phone:_____ Address: _____
Person Completing form:: _____
Agency: _____

Consent for Initial Multidisciplinary Evaluation

Purpose: Provides informed consent for evaluation and documents the date of referral for the initial evaluation.

Form use: This form is used to gain consent for a comprehensive, multidisciplinary evaluation.

Instruction:

1. Refer to the date of referral for the evaluation. For the initial evaluation this will be the date of the referral into the early intervention system.

2. Check all the areas/procedures that have been recommended. Ask parents if they have any questions about the evaluation procedures.

3. Parent/guardian check the appropriate box that indicates that they have received a copy of the rights brochure and a staff person has explained the rights brochure and procedural safeguards to the parent. (Yes or No)

4. Parent/guardian checks the appropriate evaluation consent box, date and sign the document as well as give his/her phone number and address.

5. Person completing this form signs the document and writes the name of their agency.

6. Enclose the *Rights of Infants and Toddlers with Special Needs*.

Eligibility Documentation

CHILD'S NAME: _____ **DATE OF BIRTH:** _____
Date of Form Completion _____

PART A of Definition (Attach Appropriate Documentation)

Diagnostic Instrument:_____ _____% delay in _____development
_____% delay in _____development
Administered by: _____ Agency: _____
Date Administered: _____

Diagnostic Instrument: _____ _____% delay in _____development
_____% delay in _____development
Administered by: _____ Agency: _____
Date Administered: _____

PART B of Definition (Attach Appropriate Documentation)

Diagnosed Condition: _____
Name and Title of Professional Verifying Condition:_____
Date Verified: _____

INFORMED CLINICAL OPINION (Attach Appropriate Documentation)

Rationale for Informed Clinical Opinion: _____
_____
Team Members:
Family: _____ TEIS Coordinator: _____
Evaluator: _____ Other: _____
Date Consensus Reached: _____

Eligibility for services is based on the following: (1) A review of an appropriate evaluation as described in Part "A" of the Definition; or (2) The verification of a diagnosed condition as described in Part "B" of the Definition; or (3) The attached written documentation for Informed Clinical Opinion.

Multidisciplinary Team Members (not signatures) Position
_____
_____
_____
_____
_____
_____
_____

Eligibility Documentation

Instructions

Required or Equivalent Form

Purpose: To document how an infant/toddler's eligibility for early intervention services was established. CFR 303.16; CFR 303.322

Method: Prior to the initial IFSP meeting, the incoming service coordinator completes this form which is based on information provided by the multidisciplinary team members who were involved in the evaluation and assessment activities.

If the child's identification/eligibility status is being changed due to a re-evaluation, then the designated service coordinator completes this form prior to the annual IFSP meeting or IFSP review.

Instructions:
Enter the date that the eligibility form is completed.

Part A of Definition
1. Enter the two diagnostic instruments that were used to determine eligibility for Part A of the Definition.
2. Enter the percentage of delay as measured by the instruments and the areas of development in which the delay occurs.
3. Enter the name of the professionals who administered the instruments.
4. Enter the dates that the instruments were administered.
5. Attach copies of the evaluation reports.

Part B of Definition
1. Enter the diagnosed physical or mental condition.
2. Enter the name and title of the professional verifying the diagnosis.
3. Enter the date the diagnosed condition was verified.
4. Attach copy of the Professional Verification of Current Diagnosis.

Informed Clinical Opinion (ICO)
1. State the rationale for establishing eligibility based on Informed Clinical Opinion.
2. Enter the names of the Team members who are determining the eligibility based on (ICO).
3. Enter the date that the consensus for eligibility was reached.
4. Attach the Informed Clinical Opinion Summary.

List the **Multidisciplinary Team Members** that represent two or more disciplines or professions that were involved in the multidisciplinary evaluation to establish eligibility.

Professional Verification of Current Diagnosis

Child's Name: _____ Date of Birth: _____

Child's Address: _____

Parent/Guardian Names: _____

Tennessee's Early Intervention System coordinates needed services for infants and toddlers with disabilities and their families.

Eligibility is being considered for the above named child because he/she has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

In order to establish eligibility, verification by an involved physician or other qualified professional is required.

Please complete this form for the child indicated above and return to:

Service coordinator: _____ Agency: _____

Address: _____

Phone: _____ Fax: _____

I hereby certify that the above named child has been diagnosed as having: _____

_____

(Please state name of condition or diagnosis, which could result in developmental delay).

_____ _____

Signature of Physician or other Professional | Please print or type name of physician or other professional

_____ _____

Title | Address

_____ _____

Date of Signature | City, State, Zip

Professional Verification of Current Diagnosis

Instructions

Required or Equivalent Form

Purpose: To verify a child's eligibility under Part B of Tennessee's Definition of Developmental Delay. CFR 303.16 (a) (2); CFR 303.322 (b) (1)

The term "infant and toddlers with disabilities" means a child, from birth through age two, who is eligible for early intervention services because he/she:

Part B:

has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay, i.e., known, obvious, or diagnosable conditions such as sensory losses and severe physical impairments. Examples include, but are not limited to:

- Hearing loss which can be verified or estimated to be significant as indicated through an audiological evaluation;
- Visual loss, which can be verified or estimated to be significant, for example: cataracts, glaucoma, strabismus, albinism, myopia, retinopathy of prematurity, or dysfunction of the visual cortex;
- Neurological, muscular or orthopedic impairment which prevents the development of other skills; for example, congenital dislocation of the hip, spina bifida, cerebral palsy, rheumatoid arthritis, autism, epilepsy;
- Organic conditions or syndromes which have known significant consequences; for example, tuberous sclerosis, hydrocephalus, muscular dystrophy, fetal alcohol syndrome;
- Chromosomal, metabolic, or endocrine abnormalities; for example, Down Syndrome, Klinefelter Syndrome, Turner Syndrome, hypothyroidism.

Method: The service coordinator should send this form to the involved physician or other professional who is qualified to establish eligibility by Part B of Tennessee's Definition of Developmental Delay. The physician or professional should sign the form to verify that the diagnosis is current and correct.

Instructions:

1. Complete the identifying information regarding the child.
2. Complete the information regarding the service coordinator and indicate where this form needs to be sent.
3. The physician or qualified professional states the name of the diagnosed condition or the service coordinator may state the name of the diagnosed condition if it is known.
4. The physician or qualified professional signs this form verifying diagnosis and prints or types his/her name, title, address, and the date of signature.

Review of Pertinent Records

Child's name: _____

Date this Form Completed: _____

This Form Completed by: _____

Agency: _____

Medical history and health summary _____

_____

_____

_____

Source of information, including medical records reviewed:

Source: _____ Date of record: _____

Source: _____ Date of record: _____

Source: _____ Date of record: _____

Source: _____ Date of record: _____

Information regarding vision:

_____

_____

Source: _____ Date: _____

Source: _____ Date: _____

Information regarding hearing:

_____

_____

Source: _____ Date: _____

Source: _____ Date: _____

Developmental screening summary (if applicable): _____

_____

_____

_____

_____

_____

Screening completed by: _____

Date screening completed: _____

Review of Pertinent Records

Instructions

Required or Equivalent Form

Purpose: To provide a summary of information related to the child's current health status and medical history. CFR 303.322 (c) (3) (i)

Method: Prior to determining eligibility, and as a component of the evaluation and assessment, this form should be completed by the service coordinator after gathering information regarding the child's health status and medical history, including vision and hearing status.

Instructions:

1. Summarize pertinent health status and medical history from information that was obtained from medical records and other sources.
2. Document the source of information including the medical records reviewed. Identify the date that the medical record was completed.
3. Provide a short description of vision status, including the source and the date that the evaluation, assessment, and/or screening was completed.
4. Provide a short description of hearing status, including the source and the date that the evaluation, assessment, and/or screening were completed.
5. If a developmental screening has been completed prior to this review, summarize the results. Identify who completed the screening and the date the screening was completed.

Family Assessment Summary

Child's Name: _____ Date of summary: _____
Parent or guardian: _____ Service Coordinator: _____
Agency: _____

1. Family information for the IFSP: RESOURCES and ENVIRONMENT

What are things the family likes to do?
Where does the child spend most of the day?
What are the important events that have occurred?
What are the family strengths in meeting the child's needs?

Who are the people who make up the family?
Who are the people and agencies that are helpful for the family?
What or who are the informal and formal resources for the family?

2. What are the concerns and priorities for the family?
What does the family say will help them in supporting the family's capacity to meet the developmental needs of their child in the months and year ahead? (Family Outcome)

Supports and Services That Are In Place Or Are Needed

Services such as medical, recreational, religious or social, while not covered by Tennessee's early intervention system, contribute to the family's capacity to meet the developmental needs of the child.

Support and Service	Payment Source	✓ if Needed

Sources of information:

Parent interview(s)* _____ Date(s)_____

Questionnaire(s) _____ Date(s) _____

Survey(s) _____ Date(s) _____

Other _____ Date(s) _____

***The Family Assessment must include a parent interview.**

Family Assessment Summary
Instructions

Required or Equivalent Form

Purpose: To summarize the family assessment information gathered from the required parent interview as well as questionnaires and/or checklists that document the family's description of its resources, priorities, and concerns and the identification of the supports and services necessary to enhance the family's capacity to meet the development of the child. CFR 303.322 (d)

Method: Prior to the IFSP meeting, the service coordinator should compile and summarize the information gathered through the family assessment activities. Parents should be given the opportunity to specify the information that will be discussed at the IFSP meeting.

Instructions:

1. **Family information for the IFSP:** This section should contain a summary of the family's resources as they relate to their child's development; and a description of the settings that the family has identified as natural for their family. The family will primarily determine the information that is included in this section.

2. **What does the family say will help them in supporting their capacity to meet the developmental needs of their child in the months and year ahead?** This area should contain a Family Outcome that reflects the family's desire to address their concerns, and priorities. Family Outcomes are the changes that a family wants for themselves that will enhance their capacity to meet the development of their child.

   As an example, a parent may be concerned about losing a job, which may relate to the family's health insurance coverage, which may effect health-related services the child receives. Also, the family may wish to have information regarding their current health insurance plan and alternative health coverage plans.

3. **What assistance (supports and services) or information does the family say that they need to achieve their Family Outcome?** Detail the kind of assistance the family needs to reach the desired change. The family determines the level and type of assistance.

   Using the same example, the family may need to investigate their current insurance plan and the cost and length of time allowed to continue the plan following the loss of a job. They may also need information on Tennessee insurance regulations regarding pre-existing conditions or applying for TennCare. They may need information only or assistance in calling for and completing forms.

Other Services That Are In Place Or Needed

4. **Support and Service/ Payment Source:** Indicate the name or type of services and supports that are in place or desired by the family but are not required early intervention services. List the payment source. The payment source for non-required services and supports may include the family.
5. ✓**If Needed:** Indicate by check mark which of the supports or services are not currently in place and needed. Those services that are not checked are already provided.

Local Education Agency Notification

To: _____

(Name of School System)

Date of Notification: _____ **Special Education Supervisor:** _____

Child's Name: _____ **Date of Birth:** _____
Child's Social Security Number _____
Parent(s) Name(s): _____ **Phone:** _____
Address: _____
_____

Brief History: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Parent's consent for the release of information is enclosed.

Service Coordinator completing form: _____ **Date:** _____
(Signature)

_____
(Agency)

Local Education Agency Notification

Instructions

Required or Equivalent Form

Purpose: To provide notice to the local education agency that a child who is eligible under Part C of Individuals with Disabilities Education Act (IDEA) has turned 2 years of age and is being referred to the local education agency in order to begin formal transition procedures. CFR 303.148 (b) (1)

Method: The service coordinator completes this form no later than the Part C eligible child's second birth date. The form is provided to the local education agency in which the child resides.

Instructions:

1. Complete the name of the school system and the date of notification along with the name of the special education supervisor who is receiving this form.
2. Complete the child's identifying information, including the parent's name and address.
3. Write a brief history of the child. The history should include the reason for the child's eligibility for early intervention, the length of time spent in early intervention, and any other relevant information regarding the child.
4. Attach the parent's consent for release of information to the local education agency.
5. Complete the signature with date.

Minimal Data

Date this form completed (Initial referral data):_____POE Number: _____
Name of person (primary referral source) making the initial referral: _____
Agency or Relationship to child:_____
Name of public agency receiving initial referral into the early intervention system: _____
Name of person completing this form: _____

Child's name: _____ Sex: _____ Age: _____ DOB: _____
Name of parents/legal guardian: _____
Address: _____
City: _____ State: _____ Zip: ____ County: _____
Phone (home): _____ (work): _____
Best time to reach parent/guardian:_____
(If there is not a phone number, how can the parent be contacted? _____
Reason(s) for referral (list specific concerns):_____
Plan of Action:
_____

Plan of Action (check one)		
	Parent will contact early intervention system	Time frame for contact:
	Early intervention system will contact parent	Time frame for contact:

Was the child identified as being possibly Part C eligible through a screening activity? Yes___ No ___ who completed the screening? Name: _____		
Address:	Phone:	Date of screening

Has this child/family previously received or are they currently receiving early intervention services?
Yes _____ No _____ Don't know _____
If Yes, provide service information:

Provider name	Address	Phone	Service	Date of service

	Action Taken	Explanation
	Ineligible due to child being over age 3.	
	Referred to incoming service coordinator	
	Parent chose not to participate in early intervention	
	Parent chose not to participate in early intervention but requests screenings	

Incoming service coordinator:_____ Agency:_____
Date assigned: _____

Directions to the child's home:

Minimal Data

Instructions

Required or equivalent form

Purpose: To receive information from a primary referral source when a child is initially referred into the early intervention system. CFR 303.321(d)

Method: This form may be completed by the person who is receiving the information by phone or in person; and/or the referral source may complete this form and fax or mail it to the receiving agency. This form is used for the child's initial referral into the early intervention system. If the child already has a service coordinator, then the **Agency Referral** form is used for completing a referral to another early intervention service provider and/or agency.

Instructions:

1. The POE (Point of Entry)number is the identification number assigned to the child through the TEIS office. If an agency other than TEIS is completing this form, the POE # can be obtained when the child is referred to TEIS.
2. Identify the initial date of referral into the early intervention system. CFR 303.321(d)(2)(ii) The child find system must include procedures for use by primary referral sources for referring a child to the appropriate public agency within the system that ensure that referrals are made no more than two working days after a child has been identified.
3. Identify the name of the primary referral source; and the agency or relationship of the person who is making the referral into the early intervention system. CFR 303.321(d)(3) Primary referral sources include Hospitals, including prenatal and postnatal care facilities; Physicians; Parents; Day care programs: Local education agencies; Public health agencies; Other social service agencies; and Other health care providers.
4. Identify the name of the person and the public agency who is receiving the initial referral information. CFR 303.20 Public Agency. As used in Part C, public agency includes the lead agency(TEIS) and any other political subdivision of the State that is responsible for providing early intervention services to children eligible under Part C and their families. Other political subdivisions include DMR, DOE, including TIPS, Dept of Health (CSS) and any other public agency that provides early intervention services.
5. State the name of the child who is being referred; sex; age and date of birth. Complete the information regarding the child's natural or adoptive parents or legal guardian. If there is not a phone number for the parent or guardian, obtain information which describes a method of contacting the child's family.
6. Identify the reason(s) the child is being referred into the early intervention system. List any specific concerns that the caller has regarding the child.
7. Identify whether the parent will contact Tennessee's early intervention system to arrange for intake or if someone from Tennessee's early intervention system will contact the parent to schedule the intake. State a projected timeframe for the date that the contact will take place.
8. Identify whether the child was screened prior to referral. Identify who completed the screening, the location and date of the screening.
9. Identify whether the child has previously or is currently receiving early intervention services. If yes, list the services , the provider and dates of service.
10. Identify the action taken as a result of the referral:
    (1) The child is ineligible because the age of the child is over 3. The child should be referred to the LEA with parent concurrence.
    (2) The child is referred to an incoming service coordinator who will complete intake and coordinate evaluations and assessment leading to the initial IFSP.
    (3) The parent chose not to participate in early intervention services
    (4) The parent chose not to participate in early intervention services, but would like the child to receive follow along screenings.
11. State the name of the incoming service coordinator and the date the person was assigned. CFR 303.321(e) *Timeline for public agencies to act on referrals.* (1) Once a public agency receives a referral, it shall appoint a service coordinator as soon as possible.

Central Intake

POE#: _____
Date completed: _____ Completed by: _____
Child's name: _____
Date of birth: _____ Place of birth: _____
Sex: _____ Race/Ethnicity: _____ Social Security #: _____
Address: _____
Phone: _____ Other Phone: _____
Source of referral into Part C system: _____
Date of referral into the Part C system: _____

Father's name: _____ Social Security #: _____
Address: _____ Employer/company: _____
Phone: (home) _____ Phone: (work) _____
Marital status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

---

Mother's Name: _____ Social Security #: _____
Address: _____ Employer/company: _____
Phone: (home) _____ Phone: (work) _____
Marital status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

---

Is child in state custody? If yes, Department and caseworker: _____
Address of caseworker: _____
Name of foster parent: _____
How long has child been with current foster family? _____

Have parental rights been terminated? Yes____ No ____
Is surrogate parent needed? Yes____ No ____

Please list all members of the household:

Name	Date of birth	Sex	Relationship to child	School/occupation

Language(s) spoken in home: _____
Is interpreter needed? Yes_____ No ____
If English is not primary language, how were communication needs determined? _____
_____
_____
_____

Have previous screening/evaluation/assessment been completed: Yes____ No ____
If yes, complete the following:

Screening/Evaluation/Assessment	Date performed	Performed by

Does child have diagnosed condition that has high probability of resulting in developmental delay?
Yes ____ No _____
If yes, complete the following:
Diagnosed condition: _____
Name/title of professional who can verify condition: _____
Date of diagnosis: _____

Does family have concerns? Yes _____ No _____ If Yes, describe concerns: _____
_____
_____

Please list prescribed medications and frequent over-the-counter medications for this child during the last six months.

Date	Medication/dosage	Reason prescribed	Physician

Medical History: (include dates or age and frequency of occurrence if applicable)

Measles: _____ Rubella: _____ Mumps _____ Chicken pox: _____
Sore throat: _____ Bronchitis: _____ Scarlet fever: _____
Ear infection with drainage: _____ Ear infection without drainage: _____
Pneumonia: _____ Urinary infection: _____ Asthma: _____
Rheumatic fever: _____ Heart disease: _____ Diabetes: _____ Tuberculosis: _____
Seizure(s): _____ Injury(s): _____
Surgery(s): _____
Other hospitalization(s): _____
Other: _____
_____
_____
_____
_____
_____
_____

Pregnancy Checklist
Concerns and Complications

Please check all that apply:

_____ Anemia	_____ Bleeding	_____ Diabetes
_____ Early labor	_____ Rh incompatibility	_____ Caesarian delivery
_____ Accident or injury	_____ Nutritional problems	_____ Breech delivery
_____ High blood pressure	_____ Hospitalization	_____ Normal delivery
_____ Alcohol/drug use	_____ Medication	_____ Use of forceps
_____ Emotional stress	_____ Toxemia	_____ Other
	_____ Infections	

Explanation of items marked above:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Length of pregnancy: _____ Birth weight: _____
Length of hospital stay: _____ Name of hospital: _____

Is there a family history of a medical or developmental problem such as hearing loss, etc.?

_____
_____
_____
_____
_____
_____
_____
_____
_____

Current Physicians

Name	Specialty	Address	Phone
Primary physician			

Financial supports (check all that apply):
Medicare: _____ SSI: _____CSS: _____Model Waiver: _____ Food stamps: _____
WIC: _____ AFDC: _____ TennCare: _____Other: _____

Insurance	Policy/group	Address	Phone

Current Child Care Service

Agency/individual _____
Phone: _____ Address: _____
Child schedule for service provision: _____

Current Service Providers

Agency/individual Contact person Service Phone Address
_____
_____
_____
_____
_____

Information provided by: _____
Relationship to child: _____

Other Important Information

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Central Intake

Instructions

Required or Equivalent Form

Purpose: To provide information that is necessary for establishing an individual record for the child.

Method: After referral into the early intervention system, the individual who has been assigned as the incoming service coordinator completes the Central Intake form by interviewing the parent, and/or legal guardian.

Instructions: Page 1

1. Complete the identifying information for the child, including the POE #(point of entry number for the TEIS office).

2. Identify the referral source and the date of the referral of the child into the Part C (early intervention) system in Tennessee.

3. Complete the information regarding the child's parents.

   CFR 303.19 Parent

   (a) General. As used in this part, "parent" means—

   (1) A natural or adoptive parent for a child;

   (2) A guardian;

   (3) A person acting in the place of a parent (such as a grandparent or stepparent with whom the child lives, or a person who is legally responsible for the child's welfare; or

   (4) A surrogate parent who has been assigned in accordance with CFR 303.406.

   (b) Foster parent. Unless State law prohibits a foster parent from acting as a parent, a State may allow a foster parent to act as a parent under Part C of IDEA if-

   (1) The natural parents' authority to make the decisions required under the Act (IDEA) has been extinguished under State law; and

   (2) The foster parent---

   (i) Has an ongoing, long-term (over 1-year) parental relationship with the child'

   (ii) Is willing to make the decisions required of parents under the Act; and

   (iii) Has no interest that would conflict with the interests of the child.

4. If the child is in foster care, the incoming service coordinator should consult with the Department of Children's Services (DCS) worker in order to determine the appropriate documentation regarding foster parents and to determine the need for the appointment of a surrogate parent.

   CFR 303.406 Surrogate parents

   (a) *General* Each lead agency (DOE) shall ensure that the rights of children eligible under this Part are protected if-

   (1) No parent (as defined in 303.19) can be identified;

   (2) The public agency, after reasonable efforts, cannot discover the whereabouts of a parent; or

   (3) The child is a ward of the State under the laws of that State.

5. List all the members of the household where the child resides.

6. Identify the native language of the household members.

7. If English is not the primary language how was communication needs determined? Identify through interview with collateral contacts such as the referral source, friends, other family members and individuals who knowledge of the family's communication needs.

Instructions: Page 2

1. Identify and list any previous screening(s) and/or evaluation(s) that were completed prior to intake and referral. If known, identify who completed the evaluation and/or screen; and the date that it was completed.

2. Check whether the child has a diagnosed condition that has a high probability of resulting in developmental delay; the name and title of the professional who will be able to provide the verification of the diagnosed condition, and the date the diagnosis was made, if known.

3. Describe any concerns that the family may have regarding their child or the family related to enhancing the development of the child.

4. List any medications that the child has had during the past six months, the reason for prescribed medications, and the physician who prescribed the medication.

5. Complete the medical history of the child. Check the items that the child has experienced and provide the date or frequency of occurrence, if applicable or known.

   ***Chickenpox** is caused by the varicella zoster virus, a member of the herpes virus family. Complications may consist of pneumonia and encephalitis.
   ***Measles** is caused by a virus and can be prevented by routine immunization during infancy. The chief complications are pneumonia and encephalitis.
   ***Mumps** is a contagious viral disease. There is now a safe mumps vaccine given after 15 months.
   ***Rubella** (German Measles) is an infection that is a danger to unborn infants because of the risk of developing severe congenital defects, including blindness, deafness, and heart defects.
   ***Sore throat** (acute pharyngitis) is a common complication of upper respiratory tract infections. Viruses most commonly cause it, although the bacterium *streptococcus* may also be a cause, leading to "strep throat." Streptococcal bacterium may lead to rheumatic fever or nephritis, damaging the kidney.
   ***Bronchitis** is an inflammation of the bronchial tubes (airways). It is distinguished as acute (fever, coughing and spitting with a cold) or chronic (spitting and coughing that continues for months and returns each year, lasting longer each time)
   ***Scarlet fever** is a streptococcal infection that is characterized by a pink-red rash and a strawberry tongue. It is a potentially lethal disease, but is treated with antibiotics.
   ***Ear infections.** Children are usually vulnerable to two kinds of ear infections. **Otitis externa** is also known as "swimmer's ear." It is a bacterial infection of the external ear canal, frequently the result of excess moisture. **Otitis media** is seen in about one-third of all children under the age of 6. It results from the obstruction of eustachian tube that provides drainage from the middle ear into the back of the throat and to the nose. Its most common cause is bacteria. Because half of all children with otitis media will have persistent fluid within the middle ear even after acute infections have cleared, all children should have return visits to the physician. It can impair hearing and language.
   ***Pneumonia** is an inflammation of lung tissue. It is usually caused by either a viral or bacterial infection.
   ***Urinary tract infection** is usually a bacterial infection of urethra, bladder, and/or kidney. Left untreated, the risks include scarring and permanent renal damage.
   ***Asthma** is a chronic respiratory disorder characterized by coughing, wheezing, and difficult breathing due to bronchospasm (abnormal constriction of the bronchi resulting in temporary narrowed airways). Asthmatic attacks may be caused by infection, inhaling allergens or irritating airborne substances, or exercise.
   ***Rheumatic fever**, usually a consequence of untreated strep infection, is particularly damaging to the heart.
   ***Heart disease** is a structural or functional abnormality of the heart that impairs its normal functioning. **Congenital heart disease (CHD)** is heart disease that is present at birth. Examples include defects such as *patent ductus arteriosus* and *tetralogy of Fallot.*
   ***Diabetes** is a chronic disorder of carbohydrate metabolism resulting from inadequate production or utilization of insulin. Type I is insulin-dependent and Type II is usually controlled by diet and medication.
   ***Tuberculosis (TB)** is an infectious bacterial disease. It causes damage to lungs and if the primary infection is not healed, can spread to lymph nodes or other organs. It is prevented by administering a vaccine.
   ***Seizure(s)** is an episodic, involuntary alteration in consciousness, motor activity, behavior, sensation, or autonomic function. It is a symptom of an underlying process. **Epilepsy** is recurrent seizures that are unrelated to febrile episodes. There are two principle categories of seizures: **focal or partial seizures** that begin locally in a part of the brain; and **generalized seizures** that seem to involve all of the brain from the outset. These major groups are further subdivided into types based on the clinical pattern of attacks.

Instructions: Page 3

1. Complete the pregnancy checklist by indicating the items that were concerns or complications during the pregnancy. Give a brief of explanation of the items that are marked and other important birth information that is shared during the intake.

   ***Anemia.** A condition in which the hemoglobin in the blood is too low. There are several types and causes of anemia, which along with the speed of development can affect severity. The most common type of anemia is caused by iron deficiency.

   ***Premature labor.** Labor (which is defined as the process of childbirth from dilation of the cervix to delivery of the infant and placenta) that begins before full term of pregnancy.

   ***High blood pressure.** Blood pressure that is consistently higher than 140/85-90.

   ***Vaginal bleeding.** Bright red vaginal bleeding is a serious symptom that may indicate a threatened miscarriage or an ectopic pregnancy. Some spotting or staining is common.

   ***Rh incompatibility.** Most people have in their blood a compounding factor called the Rhesus (Rh) factor. These people are call Rh-positive, while those who lack this factor are Rh-negative. There can be a problem if the mother's Rh factor is negative and the baby is Rh positive. The mother may produce antibodies to the Rh factor, which may destroy the baby's red blood cells.

   ***Toxemia (**Also known as **Pre-eclampsia**)**.** A serious complication in which the mother develops high blood pressure and edema (fluid retention that often causes swelling) and has protein in her urine.

   ***Infections.** Viral or bacterial infections pose a risk to the pregnancy or infant. The most common infections have been given the acronym *TORCH* that denotes toxoplasmosis, rubella (German measles), cytomegalovirus (CMV), and herpes. Other infections may include syphilis, polio, mononucleosis, mumps, chicken pox, and influenza.

   ***Diabetes.** An endocrine disorder that is a serious complication during pregnancy. It requires diligent monitoring of insulin and food intake to maintain normal blood sugar. Although an increasing number of babies born to diabetic mothers is increasing, there is still an increased risk of birth defects and other problems. **Gestational diabetes** is defined as diabetes that appears during pregnancy and then disappears immediately following delivery. It may pose many of the same hazards to the fetus as other types of preexisting diabetes.

   ***Caesarian birth.** A surgical incision through the abdominal wall and uterus, performed to deliver a fetus.

   ***Breech birth.** A birth in which the baby presents with the feet or buttocks first rather than the head.

   ***Normal birth.** A normal sequence of birth.

   ***Forceps delivery and vacuum extraction.** The forceps are placed on either side of the baby's head as it is beginning to come through the vaginal canal. Gently pulling on the forceps, the doctor is then able to lift the baby out. In a vacuum extraction a small plastic suction cup is placed on the baby's head. A vacuum is created which enables the doctor to lift the baby out of the birth canal by drawing on the cup.

2. Provide information about the length of pregnancy, length of hospital stay, the birth weight, and the name of hospital where the baby was born.

   A normal pregnancy is usually calculated to last 40 weeks (280 days) from the first day of the last menstrual period, or 38 weeks (266 days) from the day of conception (Tapley, 1985). A full term infant is considered to be 38 to 42 weeks gestation (37 to 41 weeks by World Health Organization standards). Babies born less than 37 weeks gestation are considered premature, and babies born post 42 weeks gestation are judged post-term (Ensher, 1986).

   Classification of prematurity (Levenson, 1996)

Borderline premature	37-38 weeks
Moderately premature	31-36 weeks
Extremely premature	24-30 weeks

Birth Weight

3000 grams	6 pounds 10 ounces	1500 grams	3 pounds 5 ounces
2500 grams	5 pounds 8 ounces	1000 grams	2 pounds 3 ounces
2000 grams	4 pounds 7 ounces	737 grams	1 pound 10 ounces

3. Describe any family history of medical or developmental problems as stated by the parent or other person(s) participating in the interview for intake purposes.
4. List the child's current physicians. The primary care physician is the physician who provides for the child's primary needs (and may act as the gatekeeper for all other medical services, as outlined by insurance requirements).

Instructions: Page 4

1. Identify the financial supports that are available to the child.
   ***Medicare.** A federal health insurance program that funds medical care for adults who are over 65 years old and for children and adults who are permanently disabled.
   ***SSI (Supplemental Security Income).** A federally funded public assistance program to people who are 65 or older or people of any age who are blind or disabled. The individual's income is an eligibility consideration.
   ***CSS (Children's Special Services).** A state program operated by the Tennessee Department of Health which provides comprehensive medical treatment to children birth to 21 years of age who have a disability and/or chronic illness. The family must meet certain financial guidelines.
   ***Medicaid Waiver.** Includes **Katie Beckett Waiver (1915(c)),** which permits exceptions to certain federal requirements to provide home and community based services as an alternative to institutionalization. This waiver, for example, permits a family with a child with special health care needs to receive Medicaid in order to have health care services and supports that enable them to keep their child at home, rather than in a hospital or institution. It is for children from birth to age 18 who would be eligible for SSI due to a serious medical condition, but whose parents earn too much money to meet the income requirements.
   ***WIC (Supplemental Food Program for Women, Infants, and Children).** A federally funded program that provides pregnant women, new mothers, infants, and young children (who qualify) with food vouchers, nutrition counseling, and referrals to health care.
   ***AFDC (Aid to Families with Dependent Children).** A federal and state funded financial assistance program that provides money to qualified individuals who have children under age 19.
   ***TennCare.** Currently, Medicaid eligible persons, children under age 19 with no access to health insurance, dislocated workers who previously had health insurance through employers and become uninsured due to a bona fide closure of a business or plant, and persons with proof of immensurability, are eligible for TennCare coverage.

2. List medical insurance (including TennCare) that is available to the child. Provide the policy/group (if applicable), the address, and phone number that is required for obtaining authorization for services.

3. Identify the agency or individual who provides child care services for this child. Include the phone number and address of the provider. Also describe the child's schedule for the child care services (such as days of the week and number of hours per day).

4. Identify the agencies or individuals who are providing services (such as physical therapy or speech therapy); the contact person for the agency (may be the primary therapist or person who schedules the appointments for the therapist); the type of therapy or service the child is receiving; the phone number; and address of the individual or agency providing the service.

5. Identify the person who provided the information for the Central Intake form and state the person's relationship to the child.

6. Describe any other information gathered during the interview for intake that appears to be important information that needs to be documented.

Informing and Consent

Regarding Payment for Early Intervention Services

Your child, _____, is eligible, or is being evaluated to determine eligibility, for early intervention services in Tennessee under Part C of the Individuals with Disabilities Education Act (IDEA).

☐ A TEIS Representative has talked with me about payment for early intervention services. We discussed options regarding accessing private insurance as a resource for payment for services. I was given opportunity to ask questions regarding things I did not understand. We have specifically discussed the following services as they relate to my child and family:

Service:	Provider (if determined)/or Potential Provider
_____	_____
_____	_____
_____	_____
_____	_____

☐ **I agree;** ☐ **I do not agree; to access private insurance coverage for payment of charges resulting from the provision of services listed above**.

_____ _____
Parent/Guardian Date

_____ _____
Parent/Guardian Date

My insurance company is _____. Confirmation and/or documentation of benefits may be obtained. I hereby give consent for my service coordinator and/or the responsible provider to confirm this information with my insurance company.

TEIS Representative who presented this information: _____
Signature /Date

The inability of the parent to pay or the parent's declining of access to insurance payment for required early intervention services will not result in the denial of services to the eligible child or the child's family.

Information Outline

Part C of IDEA requires that Tennessee's Early Intervention System (TEIS) must be the "payor of last resort" for these services. This means that your Service Coordinator must assist you in accessing all other responsible payment sources (e.g., TennCare, Family Support, Health Department, etc.) before Part C funds can be accessed.

To access payment for an early intervention service through TEIS, the following criteria MUST be met:

1. **The child must be eligible, or in the process of being determined eligible (will apply to evaluations only for determining eligibility), for early intervention services in Tennessee.**

2. **The service must be a required early intervention service as specified under IDEA [SEC. 632.(4)(E)].**

3. **If eligibility for services is established, the IFSP team (including representation from your District TEIS office) must then determine that the service is necessary to achieve a specific outcome/s for your child or family.**

4. **The service MUST be clearly documented on a current IFSP.**

5. **No other appropriate payor is available.**

Early intervention services are provided at no cost to families. (34 CFR 303.12(a)(3)[iv] and 34CFR 520(b)(3)]. The family may wish to consider whether the use of private insurance will result in:

- A decrease of lifetime coverage or any other benefit,
- An increase in the premiums, and/or
- Discontinuation of the policy

The following areas may also be considered by the family as pertinent aspects of their decision to access or decline insurance:

- Return on their investment in premiums
- The difference in potential impact on individual and group policies
- The nature of the child's disability and how it impacts the issues indicated above

Families must never feel pressured, in either direction, regarding their decision regarding the use of private insurance.

Should the family choose to access private insurance coverage for an early intervention service that is required under IDEA, TEIS will assist with out-of-pocket costs, such as a deductible and/or co-pay, thus ensuring that these services are provided at no cost to the family. This does not include incidental costs such as time required to file claims, postage, etc. This also does not apply to services that are primarily medical in nature that are needed by your child or family.

If the family declines consent for use of private insurance, TEIS will assist in exploring other possible payment options. If no other option is available, the TEIS office must purchase the service/s from a provider with whom they have an established contract and which has agreed to comply with cost rates and personnel requirements established by the State for Tennessee's Early Intervention System. TEIS will provide families a list of providers that meet these criteria upon request.

When a family has both private insurance and TennCare coverage, refusal to access private insurance coverage will also block access to TennCare reimbursement by the early intervention system and TEIS will become the responsible payor, if no other payor can be located..

AUTHORIZATION FOR PROCUREMENT AND RELEASE OF INFORMATION FOR
STATE DEPARTMENTS OF HUMAN SERVICES, HEALTH, MENTAL HEALTH AND MENTAL RETARDATION AND
EDUCATION AND RESPECTIVE AGENCIES NAMED BELOW IN THIS DOCUMENT

Name of Child: _____ Date of Birth: _____

Name of Legal Guardian: _____ ID#_____

Address: _____

_____ proposes
(Name of Direct Care Provider)

❑ to obtain from ❑ to release to ❑ to exchange with

_____

_____
(Person or agency) (Phone #)

the following information through written form and/or oral discussion of impressions or recommendations:
Parent initial the appropriate boxes.

.

- ❑ The complete record including:
  - ➢ intake forms
  - ➢ progress notes
  - ➢ reports
  - ➢ assessments/evaluations
  - ➢ Individual Family Service Plan/Reviews
  - ➢ discharge summary
- ❑ IFSP/Reviews
- ❑ Psychological Reports
- ❑ PT Reports
- ❑ Other
- ❑ OT Reports
- ❑ Most Recent Neurological
- ❑ Family Needs Assessment
- ❑ D/C summary
- ❑ Speech & Language Eval/Reports
- ❑ Hearing Screening/Evaluation
- ❑ Vision Screening/Evaluation
- ❑ Medical Reports
- ❑ Social History
- ❑ Immunization Record

Reason for request: _____

Consentor Rights- You have a right to refuse to sign this form. You have the right to refuse to release information to the individual or agency listed above. You have the right to express limitation on the use of the information to be released. The following records may not be released:

_____
_____

All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released without my written consent. I understand these reports may have information on communicable diseases.

Effective one (1) year from date signed or until_____
I understand that I may revoke this consent at any time.

_____ _____
(Date) (Signature of Parent/Legal Guardian

_____
Signature of Witness/Title)

No individual shall be denied equal educational opportunity because of his/her age. color, handicap, religion, marital or parental status, national origin, race or sex. (Revised May14, 1999)

Written Prior Notice

Child's name: _____ Date: _____

To (parent/legal guardian): _____

From (agency/service provider): _____

Address (agency/service provider): _____

_____

Phone (agency/service provider): _____

The above named agency or service provider:

_____ Proposes to begin the actions checked below; AND/OR

_____ Refuses to begin the actions checked below

Action(s) being considered:

_____ Change in the child's eligibility status (identification)
_____ Completion of initial evaluation to determine eligibility
_____ Completion of formal assessment for ongoing progress
_____ Completion of re-evaluation to determine continuing eligibility
_____ Initiation of a new service
_____ Termination a service
_____ Exit from the early intervention (Part C) system
_____ Other

---

1. Description of action(s) that is being proposed or refused by the service provider or agency:
   _____
   _____
   _____
2. Explanation of why the agency or service provider is proposing or refusing to take this action(s):
   _____
   _____
   _____
3. Factors relevant to the action(s) that is proposed: _____
   _____
   _____
   _____

Review your copy of the brochure entitled *The Rights of Infant and Toddlers with Special Needs.* It includes information to assist you in resolving any disagreement regarding the services planned for your child. If you have questions about your parental rights please call your service coordinator

Name of Service Coordinator_____ Phone Number _____

A copy of this notice has been sent to your designated service coordinator.

Written Prior Notice

Instructions

Required or Equivalent Form

Purpose: To provide written prior notice to parents a reasonable time before an agency or service provider proposes, or refuses, to initiate or change the identification, evaluation, or placement of the child, or the provision of appropriate early intervention services to the child and the child's family. CFR 303.403

Method: The agency or service provider completes and sends this notice to the child's family a reasonable time (10 days) before obtaining parental consent and completing the action being considered. Parents may provide consent (either by consent form or review/change form) earlier than 10 days if they desire to do so.

This notice must provide enough information so that the family understands the actions being considered and the reasons for taking the action.

The notice must be written so that it is understandable to the parent and provided in the native language of the parent, unless it is clearly not feasible to do so.

Instructions:

1. Complete the identifying information.
2. Check whether the agency or service provider is proposing and/or refusing to begin the action(s) being considered.
3. Identify the action(s) being considered by checking the item(s) as appropriate.
   - Change in the child's eligibility status (identification) means the child's eligibility has changed so that the child is no longer eligible because of a physical or mental condition, but is now eligible because of developmental delay; or the area of developmental delay has changed; or a child who was eligible by Informed Clinical Opinion is now eligible under another category.
   - Completion of an initial evaluation to determine eligibility.
   - Completion of a re-evaluation due to a change in the child's eligibility status (identification) such as suspicion that the child is no longer eligible due to change in diagnosis; or progress so that the child no longer has a developmental delay(s).
   - Change in a service provider.
   - Initiation of a new service
   - Termination of a service.
   - Exit from the early intervention (Part C) system
4. Describe the action(s) that is being proposed or refused in sufficient detail so that the parent fully understands.
5. Explain why the action(s) is being proposed in sufficient detail so that the parent fully understands.
6. Describe any other factors that may be relevant to the action(s) being considered.
7. Enclose *The Rights of Infants and Toddlers with Special Needs.*

Intake

Field Observation Form

1. List examples of efforts made by the experienced service coordinator to establish rapport with the child and family.

_____
_____
_____
_____

2. As you observed the experienced service coordinator listening to the family's story, describe examples of active listening that were evident.

_____
_____
_____
_____

3. Was the intake flipchart helpful to the family as a visual aide? Explain.

_____
_____
_____
_____

4. What family questions, if any, would have been difficult for you to answer?

_____
_____
_____
_____

5. Did you have any safety concerns regarding the visit? If so, describe.

_____
_____
_____
_____

6. Do you feel adequately prepared to present *The Rights of Infants and Toddlers with Special Needs* to families? If not, how can this be remedied?

_____
_____
_____
_____

7. Did the family clearly understand what the next steps would be? What was the plan of action?

_____
_____
_____
_____

8. With what part of the intake do you feel most comfortable?

_____
_____
_____
_____

9. With what part of the intake do you feel least comfortable?

_____
_____
_____
_____

10. Identify any additional training needed or concerns you have related to the intake process.

_____
_____
_____
_____